



Infectious Disease Epidemiology Section
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SHIGELLOSIS

Revised 11/09/2004

Shigellosis or bacterial dysentery is an acute infectious enteritis of humans due to *Shigella*.

Shigellae are Gram negative rods of the Enterobacteriaceae family, closely related to *E.coli*. *Shigella* are divided in 4 major O antigenic groups:

A: *S.dysenteriae*

B: *S.flexneri*

C: *S.boydii*

D: *S.sonnei*

Within each group there are several serotypes.

Epidemiology

Transmission: The transmission is fecal-oral. Person to person transmission is the most frequent route. Stools concentrations may be very high: 100,000 to 100 million bacteria /gram. As few as 10-100 organisms can cause infection, enabling person-to-person transmission where hygienic conditions are compromised.

Reservoir: Humans are the only natural hosts for *Shigella*.

Carriers: Long-term carriage is rare in industrialized countries: 1-2% excrete the organisms for >3 months. (UK study). In developing countries, particularly among children the rates of carriage are higher: 20% excrete for ≥1 months, 10% for ≥2 months.

Communicability: The source is a symptomatic individual or a short term post recovery individual. Communicability occurs during acute infection and short term carriage after recovery (4 weeks).

Common source outbreak may also occur. *Shigella* find their way in water or food and are spread through this vehicle. Food borne epidemics are usually traced to infected foodhandlers, and are associated with food eaten raw or handled after preparation.

Invasiveness: *Shigella* are able to penetrate cells, this property is extremely important for virulence. It provides the bacteria a safer environment to continue multiplying, away from antibodies, complement and phagocytes. This allows *Shigella* to be infectious with doses as low as 10-200 bacteria ingested by mouth. This low infective dose allows the infection from person to person without having the need for enrichment through water or food. The bacteria are included in a vesicle bound by a membrane and the cells survive this invasion pretty well. Eventually, after bacterial multiplication, the invaded cells suffer and die.

Endemic shigellosis appears during infancy but becomes more common among toddlers and young children. Shigellosis has become a significant problem in child care centers. Secondary attack rates in household contacts range from 10-40%.

Institutions: *Shigella* infection is a high risk for some institutions: mentally retarded and day care centers. In the United States, *S. sonnei* primarily infects young children and is a common cause of diarrheal outbreaks in child care centers. In Houston a 19 months prospective study of children in day care center showed an incidence rate of 6.6 /100 children /year with secondary cases occurring in 25% of families. Attack rates are higher in younger children than in adults. Breast fed neonates seem to be protected but bottle fed are not. Shigellosis spread easily among closed populations such as army barracks and ships.

About 25% of *S.flexneri* infections in the USA are occurring among young adult males, resulting from sexual transmission among homosexual men.

The incubation period is usually 1 to 3 days, with a range of 12 hours to 4 days; up to one week for *S. dysenteriae*.

Clinical Description

Toxigenicity: All *Shigella* produce cytotoxins, particularly by the more virulent *S.dysenteriae*. This toxin was found in 80% of stools of Bangladeshi infected with *S.dysenteriae* versus 20% with *S.flexneri*. The toxin causes (1) secretion of isotonic fluid, (2) damage to the intestinal epithelial cells by apoptosis, (3) epithelial cell death, (4) microulcer formation, (5) inflammatory response, (6) exudation of leukocytes in the bowel lumen. *Shigella dysenteriae* produces a neurotoxin (causing limb paralysis and death if injected to rabbit or mouse). This toxin does not play a role in human pathogenesis.

Asymptomatic infections result from low inoculum infections and preexisting immunity. Most infections in infants result in symptomatic disease. In common source outbreaks, attack rates range from 10 to 85% (mean 40%).

Bacterial Challenge	% with disease	
	S.flexneri	S.dysenteriae
100,000	58%	
10,000	59%	83%
200	22%	50%
10		10%

Most clinical shigellosis is gastrointestinal illness:

- Watery diarrhea, abdominal pain, fever
- Dysenteric syndrome: frequent passage of small volume bloody mucoid stools, abdominal cramps and tenesmus. More virulent strains (*dysenteriae* > *flexneri* > *sonnei*) cause a more intense dysenteric syndrome. In well nourished people, the disease is self limiting in about 7 days. Malnourished children develop a chronic relapsing disease with a 10% fatality rate.

Postdysenteric Reiter's syndrome (oculo-urethro synovial syndrome) is associated with *S.flexneri* and people with HLA –B27 antigen.

Serious complications are usually from *S. dysenteriae* infections: toxic megacolon, hemolytic uremic syndrome, toxic encephalopathy (Ekiri Sx)

Immunity: Epidemiologic observations suggest an acquired immunity to specific strains of *Shigella*. Usually *Shigella* is endemic among children and adults have much lower incidence, when a new strain is

introduced, the epidemic affects all age groups. Experiments for live oral vaccines also demonstrated a serotype specific protection.

Laboratory Tests

The diagnosis is made by identifying *Shigella* in the stools. In patients with dysenteric disease, presumptive treatment should be started immediately after collecting the samples without waiting for the results. Amebic dysentery is the main other cause of dysenteric syndrome in developing countries Isolation from the stools where numerous microorganisms are growing is enhanced by use of specific selective media to suppress the growth of usually non pathogenic bacteria to increase the contrast between *Shigella* and other bacteria so that *Shigella* colonies are easier to pick up. This is done by incorporating a dye which tags the rapid fermentors of lactose (*Shigella* are not rapid fermentors). Mac Conkey, Hektoen enteric, TTC media are used. SS media is too inhibitory for *Shigella*, particularly *S.dysenteriae*.

Stool samples will yield better results than swabs. If swabs are performed, they should go passed the anal canal. The best swabs are those of an ulcer collected under endoscopy.

Stool specimens should be collected on cotton-tipped swabs and swabs placed in a tube of Cary-Blair culture medium. (These can be obtained from the regional laboratories.) Specimens in Cary-Blair should be refrigerated and transported to the lab under refrigerated conditions as soon as possible. (If necessary to hold 48 hours or longer, freeze sample at -7°C and transport to lab in frozen state.) Complete Bacteriology Lab Slip (Lab 93).

Food samples that are sent in should be handled by the sanitarian. In the absence of a sanitarian, submit at least 100 grams (approx. 4-5 oz.) of each suspected food item (in separate containers). Be sure to keep food refrigerated (not frozen). Complete Food and Drug Lab Slip (Lab 47).

It will take more than 72 hours For the results to be available. In order to adequately investigate and identify the cause of the outbreak it is very important to obtain samples of the suspected food and several stool specimens. Confirmation of the causative organism(s) cannot be made with just one of these components.

Treatment

Fluid and electrolyte replacement if diarrhea is abundant and dehydration apparent.

Antibiotics shorten the duration and severity of symptoms and duration of carriage. Administer for 5 days.

- Fluoroquinolone: ciprofloxacin, norfloxacin
- Alternative antibiotics: ceftriaxone or cefixime or trimethoprim-sulfamethoxazole

Antimotility agents are not recommended as they may even prolong the symptomatic period. They should be limited to 1 or 2 doses and should not be administered with the antibiotics.

Surveillance

Shigellosis is a condition reportable within one business day from diagnosis.

Case Definition

Clinical description

An illness of variable severity characterized by diarrhea, fever, nausea, cramps, and tenesmus. Asymptomatic infections may occur.

Laboratory criteria for diagnosis

Isolation of *Shigella* from a clinical specimen

Case classification

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case

Confirmed: a case that is laboratory confirmed

Investigation / Intervention

The purpose of investigation is to identify cases, to differentiate *Shigella* from other bacterial infections, to determine the mode of transmission (whether from person to person or by common vehicle), to identify the population exposed to increased risk of infection and to institute disease control measures.

- Upon receipt of a report of a case of shigellosis, confirm the diagnosis.
- Request the private physician or hospital to submit a *Shigella* isolate to the nearest public health laboratory for serotyping.
- Determine if the person with shigellosis (or any ill contacts) is in a high-risk setting (such as a child care or foodhandler). If no high-risk setting is identified, then no further action is necessary.

Child care center, institution, nursing home, etc.

- Determine if any of the staff or attendees/residents are symptomatic
- Refer symptomatic persons for testing (exclude these persons from child care if the diarrhea cannot be contained in a diaper); if a large number of stool samples will be sent to the state lab for testing, notify the lab prior to submitting the specimens.
- Discuss routes of transmission and recommended control measures with the staff (use the shigellosis fact sheet as necessary) and stress the importance of thorough handwashing after toilet use/assistance, between diaper changes, before eating, and before handling/preparing food.
- Ask the director to monitor attendees/residents and staff for additional cases.
- Monitor/review reported shigellosis cases for a connection to the case in the child care center, institution, nursing home, etc.
- The child should be excluded until the diarrhea is gone or the diarrhea can be contained in a diaper or the child has been cleared by the child's physician or health department.

Foodhandlers

- Determine if any of the staff or patrons are symptomatic.
- Refer symptomatic persons for testing (exclude from food handling any symptomatic persons); if a large number of stool samples will be sent to the state lab for testing, notify the lab prior to submitting the specimens.
- Determine the food handling role of the person with shigellosis and assess his or her hygiene habits (such as handwashing, personal cleanliness, not working while ill, etc.)
- Discuss routes of transmission and recommended control measures with the staff (use the shigellosis fact sheet as necessary); stress the importance of thorough handwashing after toilet use/assistance, before eating, and before handling/preparing food and the need to not work while ill (especially with vomiting and/or diarrhea)
- Exclude symptomatic individuals from foodhandling and from direct care of hospitalized and institutionalized patients. The excluded individual should submit one negative stool culture before being allowed to return to work.

Other circumstances in which further evaluation may be necessary.

- If a physician requests family members be tested.
- If follow-up is requested by the Infectious Disease Epidemiology Section.
- If the case is suspected to be part of an outbreak.

- Determine the possible source(s) of the infection: collect information on the recent food history [such as date and time of suspected event; list of food items served; list of participants; symptoms reported; the onset date and time; etc.]. Recover all suspected foods for appropriate testing.

Prevention

Prevention of fecal oral transmission relies on:

- Handwashing: Handwashing before meals, after urination and defecation is very effective is done systematically. In day care centers toddlers who are toilet independent are at the highest risk if not properly watched and prompted to wash their hands.
- Sanitary disposal of feces
- Protection of water supply: Outbreaks of *Shigella* resulting from contaminated water supply are rare but do occur.
- Food preparation
- Control of vectors: Insects, particularly flies may play a small role in spreading the infections. In areas where feces are found in nature, flies are attracted by feces, meat and decaying fruits. They carry *Shigella* from feces to food. In a study 20% of flies were shown to carry fecal pathogens, 5% being *Shigella*
- Prophylaxis: In endemic settings, exposure occurs very frequently therefore prophylaxis would have to be long term. This would promote resistance of bacteria and is not recommended. For travelers who visit endemic areas for short periods, prophylaxis against traveler's diarrhea has been recommended by some.

Hospital precaution and isolation: Contact precautions until one stool cultures, at least 48 hours after cessation of antimicrobial therapy, is negative.

Day Care Letter

Dear School/Day Care Director,

The Office of Public Health is investigating a recent rise in the number of cases of Shigellosis in the Central Louisiana area. Shigellosis is a diarrheal illness caused by the *Shigella* group of bacteria. Most who are infected with *Shigella* experience symptoms such as diarrhea, fever, stomach cramps, nausea and vomiting. We strongly recommend that any student who develops these gastrointestinal symptoms be examined by a doctor to obtain a stool culture for diagnosis. Children who have been diagnosed with Shigellosis should not be permitted to return to school until diarrhea has ceased and stool cultures are negative for *Shigella*. If any children in your school are diagnosed with Shigellosis or develop gastrointestinal symptoms, please report the illness to the Office of Public Health.

The single most important measure to prevent transmission of Shigellosis in schools and day care centers is frequent and careful handwashing with soap, especially after going to the bathroom, after changing diapers, and before preparing foods or beverages. Some additional tips for preventing the spread of shigellosis in your facility include the following:

- dispose of soiled diapers properly
- disinfect diaper changing areas after using them
- keep children with diarrhea out of child care settings
- supervise handwashing of toddlers and small children after they use the toilet
- persons with diarrheal illness should not prepare food for others

Please contact the Office of Public Health if you have need any additional information about Shigellosis or to report an illness in your facility. Thank you for your cooperation in this matter.

Sincerely,

Physician / Pediatrician Letter

Dear Doctor,

The Office of Public Health is investigating a recent rise in the number of cases of Shigellosis in _____. We are initiating active surveillance for suspected cases. We are asking physicians within the _____ area to report suspected cases. A form for reporting is provided and we are requesting it be faxed to our local office daily / twice weekly on _____ until further notice. Additionally, we strongly suggest that children diagnosed with Shigellosis not be permitted to return to school until diarrhea has ceased and a stool culture is negative.

If you need any additional information about our active surveillance program, please contact _____, Regional Disease Surveillance Specialist at (555) 555-5555, or by email at jsnow@dhh.state.la.us. Thank you for your cooperation in this matter.

Sincerely,

Public Health Regional Administrator/Medical Director